



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WALTER DEL GALLO M D
14317 N W BLVD #A
CORPUS CHRISTI TX 77410

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-3700-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with their request for medical fee dispute resolution.

Amount in Dispute: \$4,065.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's request for medical fee dispute resolution is incomplete. 1. There are no bills or EOBs, and no position statement. 2. The requestor has not complied with the timely filing requirement. Even though there are certain exceptions to untimely requests for medical fee dispute resolution, none of those exceptions apply to the requestor's situation in this dispute. The dates of service are in 2009. The DWC MDR date stamp on the requestor's DWC-60 packet shows a received date of 6/27/11. This places the requestor's request outside DWC MDR's jurisdiction and DWC MDR now has sufficient justification to dismiss the request for medical fee dispute resolution for this reason as well as that cited under no. 1 above."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2009 Through December 9, 2009	97001-GP, 97110-GP, 97010-GP, 97140, 99212, 99215-25, 99080-69	\$4,065.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. Copies of explanation of benefits were not submitted for review.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are June 17, 2009 through December 9, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 27, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	January 17, 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.